STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001105	A. BUILDING _____ B. WING _____	C 03/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH EMERSON SURGERY CENTER	8141 S EMERSON AVE STE C INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS This visit was for the investigation of 1 Federal complaint. Complaint: IN00167992 Substantiated, Federal deficiencies related to allegation are cited. Date of Survey: 3/16/15 Facility number: 002837 QA: cjl 03/20/15	Q 000		
Q 041	416.41(a) CONTRACT SERVICES When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner. This STANDARD is not met as evidenced by: Based on interview, the facility failed to ensure that personnel received orientation for 2 of 2 staff (#2, 4). Findings: 1. On 3/16/15 at 1115 hours, staff #2 (Medical Assistant) confirmed that he/she is an employee of facility #2. On 2/25/15, he/she was asked to come to the facility to work. He/she indicated that he/she was a "gopher" for the staff working in the operating room and post anesthesia care unit. He/she indicated that this was the only time that he/she has worked at the facility.	Q 041		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Q 041	Continued From page 1 2. On 3/16/15 at 1200 hours, staff #4 (Medical Assistant) confirmed that he/she is an employee of facility #2. On 2/25/25 and 3/4/15, he/she was asked to come to the facility to work. He/she indicated that he/she was a "gopher" for the staff working in the operating room and post anesthesia care unit. He/she indicated that this was the only times that he/she has worked at the facility. 3. Personnel files/orientation were requested from staff #1 (Administrator) for staff #2 and #4 on 3/16/15 at 1030 hours and none were provided by exit on 3/16/15 at 1730 hours.	Q 041		
Q 242	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: Based on policy/procedure review, document review and interview, the facility failed to ensure that nursing personnel followed policy/procedure for instrument sterilization for 2/25/15. Findings: 1. Review of policy/procedure "Autoclave Logging", last reviewed/revised 8/6/14 indicated the following: 1. Exposure time, exposure temperature and	Q 242		

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Q 242	Continued From page 2 cycle complete are verified and yes is circled on the computer printout. 2. The patient's name , I.D. number and the OR (operating room) personnel's initials will appear on the computer printout... 6. Use logbook if no computer printout is available. 2. Review of the Autoclave Log indicated that 3 cycles were run on 2/25/15. There was no ATTEST cycle logged on the autoclave log or in review of the computer printouts for 2/25/15. 3. Facility guidelines for ATTEST cycles testing frequency is every day that autoclaves are used. 4. On 3/16/15 at 1540 hours, staff #1 (Administrator) confirmed that an ATTEST cycle is run each day that a load is run and 2/25/15 did not have autoclave computer printouts for ATTEST test.	Q 242		